TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Back to Action Inc

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-3497-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 31, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Med recs provided to support charges billed."

Amount in Dispute: $360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the records with the initial billing from the requestor finding no evidence one-on-one patient contact was conducted with the provision of the therapeutic exercises although the exercise sessions lasted approximately an hour for each date. Texas Mutual denied payment for this reason with message modifiers 225 and 892. The requestor submitted requests for reconsideration (RFR) but submitted no documentation demonstrating the one-on-one required patient contact."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3 – 4, 2017	97110	$360.00	$307.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $360.00 for professional medical services rendered on January 3 – 4, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" and 225 – "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information."

   Review of the submitted documentation finds for date of service January 3, 2017 a "Follow Up Visit Note." This document contained an "Evaluation" and "Assessment." In this section the physical therapist documents, "The resistance was decreased to 2 pounds, but still complained so the exercise was terminated." This document was signed by the treating physical therapist.

   A "Reevaluation Visit Note" was found for date of service January 4, 2017. In the section of "Evaluation" and "Assessment" the documentation states, "…improved his left knee extension by 5 degrees, and increased bilateral knee flexion by 5 degrees respectively…" this document was signed by the treating physical therapist.

   Review of these documents find for both dates of service in dispute, the documentation supports the therapist had one on one contact during the therapy session. The carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The Medicare payment policy associated with Outpatient Rehabilitation Service is found at www.cms.gov,

   Publication 100-4, Medicare Claims Processing Manual, Chapter 5, Section 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services (Rev. 3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16) (Rev. 3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)

   Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

   Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are

provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

Submitted Code	Practice Expense (PE) x Practice Expense GPCI	Work Expense (WE) x Work GPCI (Full payment)	Malpractice Expense (MP) x Malpractice GPCI (Full payment)	PE, + WE, + MP X Conversion Factor	Medicare Physician Fee Schedule MPFS	WE x allowable	MP x allowable	50 per cent of PE	Total
97110	0.45 x 0.929 = 0.418	0.45 x 1.000 = 0.450	0.02 x 0.809 = 0.016	0.418 + $0.450 + 0.016 = 0.884 X 35.8887 = $31.726 or $31.73	$31.73	.450 x 31.73= $14.279	0.016 x 31.73 = $0.508	0.418 x 31.73 = $13.263 x 50% = $6.632	$14.279 + $0.508 + $6.632= 21.419 or $21.42

The medical bill for both dates of service indicates (4) units. The first unit will be reimbursed as (DWC Conversion Factor/Medicare Conversion Factor) x Allowable amount = Maximum Allowable Reimbursement or $57.5/$35.8887 x $31.73 = $50.84.

The remaining (3) units will be reimbursed based on multiple procedure discounting reduction shown above. (DWC Conversion Factor/Medicare Conversion Factor) x Amount reduced by multiple procedure discount equals Maximum Allowable Reimbursement or $57.5/$35.8887 x $21.42 x 3 units = $102.96.

For date of service January 3, 2017 the total MAR is $50.84 + $102.96 = $153.80. For date of service January 4, 2017 the total MAR is $50.84 + $102.96 = $153.80. For a total of $307.60

3. The total maximum allowable reimbursement is $307.60. The carrier previously paid $0.00. The balance of $307.60 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $307.60.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $307.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 25, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.